IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 12, 2003

Re: IRO Case # M2-03-0790

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Neurological Surgery. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient is a 42-year-old male who on ___ developed back and neck pain with pain radiating into both upper and lower extremities when a cubical fell on him. This led to multiple operations on the patient's back and neck, and an unrelated operation on femur. The patient continues to have numbness, a feeling of weakness and pain in all extremities, with the lower extremities being somewhat more severe.

Requested Service
ALIF with femoral & iliac allogra and internal fixation, removal of bone growth stimulator and exploration of fusion.

Decision
I agree with the carrier's decision to deny the requested treatment.

Rationale
The patient has arachnoiditis, which is probably a major source of his symptoms, and this would be made worse by the proposed extensive operative procedure. According to the records presented for this review there is no L5 root compression or other major nerve root compression on the CT myelographic evaluation. Discography showed nothing but disk concordant pain. The patient is depressed, and in the face of this, pain-relieving procedures are non beneficial in a high percentage of cases. There is no mention of pseudoarthrosis on any of the imaging reports, and there is nothing to suggest instability, despite retrolisthesis of a minor degree at the L3-4 level.

Although it probably would also be unsuccessful, a more limited procedure might be considered if indeed pseudoarthrosis with instability were definitely diagnosed. But it is doubtful that his multiple symptomatology would be significantly relieved by such a procedure.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (28 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions, a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to:
Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308(t)(2)).

Sincerely,

In accordance with Commission Rule 102.4 (b), I hereby certify that a copy of this Independent Review Organization (IRO) decision was sent to the carrier and the requestor or claimant via facsimile or US Postal Service from the office of the IRO on this 13th day of May 2003.